DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code, §1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to Chapter 9 of Title 29 of the District of Columbia Municipal Regulations entitled "Qualifications for a Disproportionate Share Hospital." The effect of these rules is to establish a new payment distribution for those hospitals who qualify as disproportionate share hospitals (DSH) in the District of Columbia. The DSH payment methodology provides a payment to hospitals that serve a disproportionate share of low income or uninsured patients. This payment is made in addition to the regular payments such hospitals receive for providing inpatient hospital care to Medicaid recipients.

These rules will: (1) create a new qualifying criterion for DSH in the District which would allow Washington Hospital Center to qualify as a DSH; (2) modify the distribution of DSH funds paid to District hospitals by increasing the amount paid to Children's Hospital to ensure that children in the District continue to receive the highest quality of care consistent with the Mayor's FY 2007 priority to improve the health of children; (3) provide funding to expand coverage of the Medicaid program for a population or service not previously covered as of October 1, 2006; and (4) create a prospective payment reimbursement methodology for DSH funds.

The District of Columbia Medicaid Program is also amending the District of Columbia State Plan for Medical Assistance (State Plan) to reflect these changes. The Council of the District of Columbia has approved the attendant State Plan amendment.

A notice of proposed rulemaking was published in the *D.C. Register* on February 2, 2007 (54 DCR 1041). Comments were received. No substantive changes have been made. These rules shall become effective on April 1, 2007 if the corresponding State Plan amendment has been approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) with an effective date of April 1, 2007 or the effective date established by CMS in its approval of the corresponding State Plan amendment. If approved, the Department of Health will publish a notice which sets forth the effective date of the rules.

Section 908 (QUALIFICATIONS FOR A DISPROPORTIONATE SHARE HOSPITAL) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

908 QUALIFICATIONS FOR A DISPROPORTIONATE SHARE HOSPITAL

908.1 A hospital located in the District of Columbia shall be deemed a disproportionate share hospital (DSH) for purposes of a special payment adjustment if a hospital has at least one percent (1%) Medicaid utilization and the hospital has at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals; and

(a) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals in the District who are Medicaid providers; or

(b) The hospital's low income utilization rate exceeds twenty-five per cent (25%); or

(c) The hospital provides the greatest number of Medicaid inpatient days of all District hospitals and does not qualify as a disproportionate share hospital under sections 908.1 (a) or (b).

908.2 A hospital whose inpatients are predominately individuals under the eighteen (18) years of age or did not offer non-emergency obstetric services to the general population as of December 1, 1987, shall not be required to have two obstetricians as required in section 908.1.

908.3 Not later than June 1st of each year, all participating District hospitals shall file such information as the Department requires including, but not limited to revenue, charges, charity care, uncompensated care costs, and Medicaid utilization for its cost reporting period ending in the previous calendar year. This data, together with data from each hospital's cost report as filed for the same period shall be used to determine participation in the disproportionate share distribution.

908.4 The District of Columbia may limit the total DSH payments that it will make to qualifying DSH hospitals beginning April 1, 2007 and each fiscal year thereafter. The annual District DSH limit in a fiscal year shall be equal to the District's annual Federal DSH allotment, expressed in total computable dollars, for the same fiscal year reduced by the lesser of:

(a) The sum of the following:

(1) The total amount expended by the District for services provided in the same fiscal year under the authority of the Medicaid Waiver to enable the District government to expand coverage of the Medicaid program to childless adults 19 to 27 and 50 to 64 years of age;

(2) The total amount expended by the District for services provided in the same fiscal year under the authority of any approved State Plan

amendment, waiver modification, section 1915 Medicaid Waiver, section 1115 Medicaid Waiver, or HIFA Waiver enabling the District government to expand coverage of the Medicaid program for a population or service not covered as of October 1, 2006; and

(3) Five million, six hundred thirty-six thousand, five hundred and seventy–one dollars ($5,636,571) paid to the D.C. Health Care Safety Net Administration for inpatient hospital services and coordinated health care for the uninsured under the D.C. Healthcare Alliance Program; or

(b) Twenty million, seventy-nine thousand, four hundred and twenty-seven dollars ($20,079,427) in the District's fiscal year 2007. In subsequent District fiscal years, the amount in this section shall be 24.7% of total computable dollars.

908.5 The total amount expended by the District for services provided under section 908.4(a)(1) and (2) shall be an amount, as determined ninety (90) days after the end of each fiscal year, which shall equal the sum of:

(a) The actual liabilities incurred and received by the District for waiver services to expand coverage of the Medicaid program to childless adults 19 to 27 and 50 to 64 years of age and other waiver and State Plan services to expand coverage of the Medicaid program for a population or service not covered as of October 1, 2006; and

(b) The District's best estimate of incurred, but not yet received, liabilities as of the same date. The District's best estimate shall not be subject to revision at a later date.

908.6 Effective April 1, 2007, any hospital which meets the disproportionate share eligibility requirements set forth in sections 908.1 and 908.2 shall be paid on a prospective basis consistent with the requirements set forth below:

(a) The prospective payment shall be developed by establishing a base year to determine the adjustment percentages, operating costs for inpatient hospital services, uncompensated care, and any other factor that is required for purposes of determining the amount of each hospital's DSH payment adjustment pursuant to these rules;

(b) The base year financial data and other information shall be established using un-audited financial data and other information for the hospital's fiscal year that ends on or after January 1, 2004 but not later than December 31, 2004;

(c) Not later than October 1, 2011 and every five (5) years thereafter, the base year financial data and other information shall be updated. The base year financial data and other information established during rebasing shall be developed using audited financial data and other information;

(d) Payments shall be made on a quarterly basis; and

(e) Each qualifying hospital shall comply with the requirements set forth in section 908.3.

908.7 Each new provider shall be eligible to receive a DSH payment adjustment calculated in accordance with this section. Each new provider shall be required to submit a complete hospital fiscal year of data as required by the Medicaid program, including but not limited to revenue, charges, charity care, uncompensated care costs, Medicaid utilization, Medicaid patient days, etc. The DSH payment adjustment shall be calculated taking into account the data submitted by each qualifying new provider and all other qualifying hospitals. The DSH payment adjustment to each new provider shall begin the following District fiscal year after the hospital qualifies as DSH hospital.

908.8 Effective April 1, 2007, and in accordance with section 1923(c)(3) of the Social Security Act, the District of Columbia Medicaid Program shall establish four (4) categories of hospitals to pay each hospital that qualifies as a disproportionate share hospital (DSH):

(a) The first category shall include the private hospital that provides the greatest number of Medicaid inpatient days of all hospitals in the District of Columbia as defined in section 908.1(c);

(b) The second category shall include the public psychiatric hospitals, which includes St. Elizabeth's Hospital;

(c) The third category shall include the District's licensed specialty hospital that provides acute care pediatric services and provides the greatest number of Medicaid inpatient days of all hospitals in this category; and

(d) The fourth category shall include all remaining qualifying private hospitals that are not included in the first or third categories.

908.9 The annual District DSH limit shall be distributed as follows:

(a) The private qualifying DSH hospital as defined in section 908.1(c) shall be paid an amount based upon the formula set forth in section 1923(c)(1) of the Social Security Act, which is the product of the amount established under section 1923(c)(1)(A) times the adjustment percentage established

under section 1886(d)(5)(F)(iv) not to exceed $3,000,000. If, in a given year, a hospital no longer qualifies as a DSH hospital under subsection 908.1(c), any funds received under this subsection during that fiscal year shall be refunded to the Department of Health, Medical Assistance Administration (MAA) and redistributed proportionately among the qualifying hospitals in the second, third and fourth categories;

(b) Each qualifying public psychiatric DSH hospital shall be paid an amount based upon the formula set forth in section 1923(c)(1) of the Social Security Act, which is the product of the amount established under section 1923(c)(1)(A) times the adjustment percentage established under section 1886(d)(5)(F)(iv);

(c) The qualifying private pediatric hospital in the third category shall be paid the sum of an amount based upon the formula set forth in section 1923(c)(1) of the Social Security Act, which is the product of the amount established under section 1923(c)(1)(A) times the adjustment percentage established under section 1886(d)(5)(F)(iv) and twelve million five hundred thousand dollars ($12,500,000); and

(d) Each qualifying private DSH hospital in the fourth category, shall be paid an amount based upon the formula set forth in section 1923(c)(1) of the Social Security Act, which is the product of the amount established under section 1923(c)(1)(A) times the adjustment percentage established under section 1886(d)(5)(F)(iv).

908.10 Beginning August 1, 2007, and annually thereafter, MAA may recalculate and adjust the DSH payments to eligible qualifying hospitals subject to the requirements set forth in this section. The payment distribution to all hospitals shall be recalculated and the payment adjusted beginning the District's fiscal year following August 1st, if, in any year subsequent to the establishment of the base year, the percentage of any hospital's eligible DSH payment to the total eligible DSH payments of all qualifying hospitals results in an increase or decrease in excess of ten percent (10%) from that hospital's base year percentage of eligible DSH payments.

908.11 Any payment adjustment computed in accordance with subsection 908.9 is subject to the limit on payments to individual hospitals established by section 1923(g) of the Social Security Act. The amount of any payment that would have been made to any hospital, but for the limit on payments established by section 1923(g), shall be distributed proportionately among the remaining qualifying hospitals in the second, third and fourth categories, based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

908.12 Any DSH payment adjustments computed in accordance with section 908.9 are subject to the limits on payments to Institutions for Mental Disease, established by section 1923(h) of the Social Security Act. The amount of any payment that would have been made to a public or private hospital, but for the limit on payments established by section 1923(h), shall be distributed proportionately among the remaining qualifying hospitals in the third and fourth categories, based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

908.13 If, during any fiscal year, the annual District DSH limit is not sufficient to pay the full amount of any DSH payment adjustment computed in accordance with 908.9, then each hospital in the first, second, third and fourth categories shall be paid a proportional amount of their computed DSH adjustment amount. The final DSH payment for each hospital shall equal the product of its DSH payment adjustment computed in accordance with section 908.9 and a fraction determined by the following formula: The numerator shall equal the annual District DSH limit. The denominator shall equal the aggregate DSH payment adjustment for all hospitals computed in accordance with section 908.9 of these rules.

908.14 MAA shall conduct audits to ensure compliance with the requirements set forth in section 1923(j) of the Social Security Act. Each hospital shall allow appropriate staff from the Department of Health or authorized agents of the District of Columbia government or federal government access to all financial records, medical records, statistical data and any other records necessary to verify costs and any other data reported to the Medicaid program.

908.99 DEFINITIONS

908.99 For purposes of this section, the following terms shall have the meanings ascribed:

Annual District DSH limit - The annual District established aggregate limit for DSH payments. This term shall not be construed as the annual Federal DSH allotment for the District of Columbia.

Base Year - The standardized year on which rates for all DSH qualifying hospitals are calculated to derive a prospective DSH reimbursement rate.

Charity Care - Care provided to individuals who have no source of payment, third-party coverage or personal resources. Charity care shall not include contractual allowances or discounts except those for indigent patients who are eligible for services under a sliding fee scale.

Fiscal Year – For the District of Columbia shall be the time period beginning October 1st through and including September 30th.

Low Income Utilization Rate - The sum of two (2) fractions, both expressed as percentages. The numerator of the first fraction is the sum of: 1) total revenues paid the hospital during its fiscal year for Medicaid patient services; and 2) the amount of any cash subsidies for patient services received directly from the State or the District government. The denominator shall be the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same fiscal year. The numerator of the second fraction is the total amount of the hospital's charges for inpatient hospital services, which are attributable to charity care in the fiscal year, minus the portion of the cash subsidies reasonably attributable to inpatient services. The denominator of the second fraction shall be the total amount of the hospital's charges for inpatient hospital services in that fiscal year.

Medicaid Inpatient Utilization Rate - The percentage derived by dividing the total number of Medicaid inpatient days of care rendered during the hospital's fiscal year by the total number of inpatient patient days for that year.

Medicaid Patient Days - A patient day paid for by any state program operating under Title XIX of the Social Security Act. A day, for which the Medicaid program pays only a deductible, or co-payment, shall not be counted as a Medicaid patient day.

New Provider - Any District hospital that meets the qualifications of a DSH hospital pursuant to the requirements set forth in section 908.1 after October 1, 2006 or subsequent rebasing as set forth in section 908.6.

Total Computable Dollars - Total Medicaid DSH payments, including the federal and District share of financial participation.

Uncompensated Care – The cost of inpatient and outpatient care provided to Medicaid eligible individuals and uninsured individuals as described in section 1923(g)(1)(A) of the Social Security Act. Such uncompensated care cost shall include the cost of providing inpatient and outpatient hospital services to individuals who either are eligible for medical assistance under the District State plan or have no health insurance (or other source of third party coverage) for services provided during the year, net of payments other than under this section, and by or for uninsured patients. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by the District or a unit of local government shall not be considered to be a source of third party payment. Such uncompensated care cost shall not include charges written off to bad debts or bad debt allowances included as an expense in a hospital's operating costs.

DISTRICT DEPARTMENT OF TRANSPORTATION

NOTICE OF FINAL RULEMAKING

The Director of the District Department of Transportation, pursuant to the authority set forth under sections 3(b), 5(4)(A), and 7 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137, D.C. Official Code §§ 50-921.02(b), 50-921.04(4)(A), and 50-921.06); Section 604 of the Fiscal Year 1997 Budget Support Act of 1996, effective April 9, 1997 (D.C. Law 11-198, D.C. Official Code § 10-1141.04); and Mayor's Order 96-175 (December 9, 1996), hereby gives notice of the adoption of the following amendments to § 225 of Chapter 2 of Title 24 of the District of Columbia Municipal Regulations (DCMR) (Public Space and Safety). The amendments update § 225 to create a new category of public space permit fees related to receptacles for construction debris (e.g., Dumpsters ™).

Notice of Proposed Rulemaking (Rulemaking) was published in the *D.C. Register* on January 12, 2007, at 54 DCR 300. The only comment received on the Rulemaking urged an increase in the public space permit fees for receptacles for construction debris from $19 to $750. The Department has decided against increasing the fees as suggested.

These final rules will be effective upon publication of this notice in the *D.C. Register*.

24 DCMR, Chapter 2, Section 225, PUBLIC SPACE PERMIT FEES, is amended as follows:

Subsection 225.1 is amended to add the following:

225 PUBLIC SPACE PERMIT FEES

225.1 The following schedule of fees shall apply to public space permits:

Temporary Occupation of Public Space

Receptacles for construction debris (e.g., Dumpsters ™) placed in public space in areas zoned CR, C-1 through C-5, CM, M, SP-1 and SP-2, and W-1 through W-3.

Monthly fee for each construction receptacle during the first three (3) months the receptacle occupies public space.....$20.00

Monthly fee for each construction receptacle during months four (4) and five (5) the receptacle occupies public space.....$75.00

Monthly fee for each construction receptacle that

occupies public space during months six (6) and thereafter.....$150.00

Receptacles for construction debris (e.g., Dumpsters ™) placed in public space in areas zoned R-1 through R-5.

Monthly fee for each construction receptacle during the first two (2) months the receptacle occupies public space.....$20.00

Monthly fee for each construction receptacle during month three (3) the receptacle occupies public space.....$50.00

Monthly fee for each construction receptacle during months four (4) and five (5) the receptacle occupies public space.....$100.00

Monthly fee for each construction receptacle that occupies public space during months six (6) and thereafter.....$200.00

UNIVERSITY OF THE DISTRICT OF COLUMBIA

NOTICE OF FINAL RULEMAKING

The Board of Trustees of the University of the District of Columbia, hereby gives notice that on March 21, 2006, pursuant to the authority set forth under §201(a) of the District of Columbia Public Postsecondary Education Reorganization Act Amendments ("Act") effective January 2, 1976 (D.C. Law 1-35; D.C. Official Code §38-1202.06), it adopted as final rulemaking amendment of Section 728 to Chapter 7 of Title 8, DCMR, entitled "Tuition and Fees" to complete the first fee tuition and fees increase at the University in eight years. This amendment was published as a proposed rulemaking at 53 D.C. Register 576 on January 27, 2006 for comments. Changes resulting from comments are the replacement of the word "beginning" with the word "for" in the introductory clause to Section 728.1 and the correction of the inadvertent imposition of the Law Student Activity fee from "per semester" to "per year," published as a proposed rulemaking at 53 D.C. Register 2414 on December 8, 2006. This section will be effective upon publication in the D.C. Register.

Section 728 of Title 8, DCMR, is amended as follows:

728 TUITION AND FEES: Degree-granting Programs

728.1 The following tuition rates shall be in effect for Fall 2007 for all students of the University for each semester:

Undergraduate students (D.C. residents)	Increase $15.00 per credit hour to $105.00 per credit hour
Undergraduate students (non-residents)	Increase $15.00 per credit hour to $215.00 per credit hour
Graduate students (D.C. residents)	No increase, to remain at $225.00 per credit hour
Graduate students (non-residents)	No increase, to remain at $350.00 per credit hour
Law students (D.C. residents)	No increase, to remain at $3,675.00 per semester
Law students (non-residents)	No increase, to remain at $7,350.00 per semester

728.2 Reserved

728.3

(a) Each semester and summer of enrollment beginning Fall Semester 2006, each undergraduate and graduate student shall pay the following mandatory fees:

(1) Activity Fee	Increase $10.00 per semester to $35.00 per semester
(2) Athletic Fee	Increase $15.00 per semester to $105.00 per semester
(3) Health Services Fee	No increase, to remain at $25.00 per Semester
(4) Technology Fee	Increase $10.00 per semester to $50.00 per semester
(5) Student Center Fee	Increase $20.00 per semester to $95.00 per semester

(b) Beginning Fall Semester 2006, each law school student shall pay the following mandatory fees:

(1) Law School Student Activity Fee	$210.00 per year
(2) Law School Materials/Technology	Increase $60.00 per semester Fee to $85.00 per semester

728.4 The University shall charge the following miscellaneous fees to all students.

(a) Application Fee, Graduate	Increase $25.00 to $75.00
(b) Application Fee, International	Increase $50.00 to $100.00
(c) Application Fee, Undergraduate	No increase, to remain at $50.00
(d) Change of Course Fee	No increase, to remain at $10.00
(e) Credit by Special Examination	No increase, to remain at $50.00
(f) Duplicate I.D. Card Fee	Increase $5.00 to $15.00
(g) Enrollment Fee, Domestic Students	Increase $50.00 to $100.00
(h) Enrollment Fee, International Students	Increase $50.00 to $100.00

(i) Graduate Writing Proficiency Exam	No increase, to remain at $50.00
(j) Graduation Fee, Graduate	No increase, to remain at $65.00
(k) Graduation Fee, Undergraduate	No increase, to remain at $50.00
(l) Laboratory Fee	No increase, to remain at $50.00
(m) Late Application	Increase $50.00 to $100.00
(n) Late Application for Tuition Installment Plan	Increase $5.00 to $25.00
(o) Late Registration	No increase, to remain at $50.00
(p) Law School Graduation Fee (3 yr only)	No increase, to remain at $325.00
(q) New Student Orientation Fee	No increase, to remain at $15.00
(r) Readmission Application Fee	Increase $5.00 to $20.00
(s) Returned Check Fee	No increase, to remain at $35.00
(t) Student Health Insurance	No increase, to remain $175
(u) Transcript, each after first one	No increase, to remain at $5.00
(v) Transcript, first one	No increase, to remain free
(w) Transfer Student Fee	Increase $50.00 to $125.00
(x) Tuition Management System	No increase, to remain at $30.00
(y) Withdrawal Fee	Increase $2.00 to $7.00

728.5 Each student who does not have health insurance coverage or other means of health care financing shall obtain health insurance designated by the University or join a health maintenance organization designated by the University.

728.6 A separate laboratory fee of Fifty Dollars ($50.00) shall be charged for each laboratory course. The laboratory fees collected under this subsection shall be reserved for expenditures related to improvement and maintenance of University laboratories.

728.7 The technology fees assessed and collected under this section shall be reserved for expenditures related to improvement and maintenance of technology available to university students, faculty, and staff.